FOUR APPROACHES TO
EMERGENCY CONTRACEPTION IN ECUADOR

Collaborating Institutions:

International Center for Research on Women (ICRW)

Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF)

Centro Obstetrico Familiar (COF)

Centro Ecuatoriano para la Promocion y Accion de la Mujer (CEPAM)

Direccion General de Higiene Promocion de la Salud del Distrito Metropolitano de Quito

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Background

Ecuador has a number of public and private organizations involved in a broad range of activities in the area of reproductive health. Among other activities, these organizations have developed diverse strategies directed at the prevention of early pregnancy, reductions of the risk of induced abortion and reduction of sexually transmitted diseases, including HIV/AIDS. Through their different projects, these organizations have also tried to include activities aimed at special groups, such as adolescents, commercial sex workers, women who are victims of violence, and rural indigenous populations. These special groups lack access to integrated medical services that include family planning as a component of reproductive and sexual health.

It was within this context that, in 1996, the International Center for Research on Women (ICRW), developed an operations research project in collaboration with four Ecuadorian institutions, to examine the most effective ways to provide emergency contraception services in Ecuador. The four collaborating institutions are the Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF), the Centro Obstetrico Familiar (COF), the Centro Ecuatoriano para la Promocion y Accion de la Mujer (CEPAM), and the Direccion de Higiene Promocion de la Salud del Distrito Metropolitano de Quito. The project, "Four Approaches to Providing Emergency Contraception in Ecuador," was part of a series of family planning and reproductive health operations research activities under the Population Council's Operations Research in Latin America Project (INOPAL III). ICRW, as a subcontractor to the Population Council, was responsible for coordinating research on the integration of gender into program strategies to maximize the effectiveness of service provision. The four Ecuadorian institutions involved in the projects have worked together on the design and implementation of different components of the project, according to their areas of specialization and experience.

Collaborating Institutions

ICRW, is a private, non-profit organization, dedicated to promoting social and economic development with women's full participation. ICRW generates research and provides technical assistance on women's productive activity, their reproductive and sexual health and rights, their status in the family, their leadership in society, and their management of environmental resources. ICRW works in collaboration with researchers and professionals in Asia, Africa and Latin America to jointly carry out research and disseminate findings at the policy level.

Based on an assessment undertaken in January 1996, and following an evaluation process conducted by the Emergency Contraception Consortium, ICRW identified the following four institutions to participate in the project.

Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF): CEMOPLAF is a non-governmental family planning organization (NGO) founded in 1974. It attends an average of 25,000 users per month, primarily offering services to the low-income populations in urban, rural and indigenous areas. CEMOPLAF operates 21 clinic centers in 10 provinces, and 13 mobile services that are serving as new models of care allowing services to be provided in localities that are difficult to reach. CEMOPLAF also offers several programs, among which the community-based distribution of family planning in indigenous communities is a highlight. This project supports community leaders and bilingual health promoters who work in four provinces through 116 distribution posts. Services are offered through community physicians and associated health professionals who provide family planning at low cost, in both urban and rural areas. Social Marketing, another CEMOPLAF program, promotes the use of contraceptives among those segments of the middle and lower income populations, who can afford to pay some amount for services. CEMOPLAF has a Department of Research through which a variety of studies are conducted, including operations research.

Centro Obstetrico Familiar (COF): COF is a non-profit, social services NGO, which began educational activities in reproductive health for adults in 1984. COF's activities have emphasized obstetric care, family planning and pediatrics. COF's central focus has been to provide quality care in reversible family planning methods to low-income people in the urban marginal areas of Quito. Since 1991, COF has run an integrated Program for Adolescents. This program offers educational activities and services in a variety of areas including sex education, self-esteem, values, anatomy and physiology of the male and female reproductive systems, responsible sexuality, sexually-transmitted diseases (STDs) and HIV/AIDS, family planning, and youth leadership training, among others. COF trains youth from high schools in urban marginal areas of the city of Quito in the above-mentioned themes to serve as heath education promoters among their peers. Some promoters also receive training in order to distribute certain contraceptive methods like pills or condoms, to other sexually active youth. As a result of this program, COF has become a pioneer in service provision and information on sexual and reproductive health for adolescents in Ecuador. The Adolescents Program has reached 50,000 students in public and private schools throughout Quito. It has also reached 10,000 youth who are not in the formal education sector. In the emergency contraception project, COF has participated through its five agencies, the Program for Adolescents, 10 health centers working with the Ministry of Public Health, the Cipriana Duenas Medical Training Center, the COF agencies in Esmeraldas, the COF agencies in Tena, and the Department of Health.

Centro Ecuatoriano para la Promocion y Accion de la Mujer (CEPAM): CEPAM offers integrated health and legal services for women in abusive situations. CEPAM is a pioneer in promoting the use of emergency contraception among its clients. Since its inception, in 1996, the reproductive health clinic of CEPAM has offered services to approximately 1100 women. It also provides training in gender, reproductive health, family planning, and domestic violence to health personnel in six sub-centers of the Ministry of Public Health and the Southern District of Quito. For the purpose of the emergency contraception project, CEPAM coordinated efforts through 11 health sub-centers, CEPAM Guayaquil, SENDAS, another NGO in Cuenca, Utopia, INRED, the Medical/Legal Service of the Police Dept., and three Women's Commissariats.

Municipio de Quito/Prosaplan/DGH/MDMQ : The Municipality of Quito , under the Directorate General of Hygiene, provides basic health services to the urban marginal population that is not served by the Ministry of Public Health. It administers one hospital center and five health teams that visit 38 neighborhoods once a week. Since 1995, the Municipio has been in charge of the "Women, Integrated Health and Education" project, aimed at strengthening the capacity of providers to serve the health needs of poor women. The Directorate General of Hygiene is the normative, regulating agency in the city of Quito, and is also responsible for policies in the areas of health promotion, preventive and curative services, and rehabilitation. The Directorate, through its decentralization policies, and with the support and participation of the citizens of Quito, has undertaken a number of sustainable social and health projects. For the emergency contraception project, the Directorate participated through 37 community health posts, 20 crafts training centers, and 2 municipal high schools.

Reproductive Health in Ecuador

Ecuador has approximately 12,174,000 inhabitants and a total fertility rate of 3.6, among the highest in Latin America. In Ecuador, 40 percent of the population is less than 15 years of age. The population in the 15-49 age range has increased to 5,890,000, of which 2,923,000 are women. In spite of the fact that 92% of women of reproductive age are familiar with modern family planning methods, only 48% of women report using these methods. As a result, the rates of unwanted pregnancy continue to be high. According to the 1994 national survey, 19% of all pregnancies are unplanned, and 8% are of these are interrupted pregnancies. These rates of unwanted pregnancy increase among women with little or no education to 39%.

With regard to adolescents, the cause of pregnancy in this age group is basically lack of knowledge about the risk of pregnancy, which indicates the lack of information and services available to this group. In addition, the early age of initiation of unprotected sexual also contributes to the number of unintended pregnancies. In Ecuador, 25% of mothers are adolescents.

In Ecuador, the use of modern contraceptive methods is as follows: the most requested method is female surgical sterilization (19.8%); followed by the IUD (11.8%); oral contraceptives (10.2%), traditional methods (11.1%) and the condom (2.6%). Private doctors and clinics are the principal source for obtaining most contraceptive methods (26.3%), followed by the Ministry of Public Health (23.4%), and the pharmacy (16.4%). These three groups meet two thirds of the demand for contraceptives in the country.

With regard to emergency contraception, some physicians are familiar with this method, but its use has been primarily prescribed for victims of sexual violence. There are no registers of use, however, CEPAM was a pioneer in the use of this method for unwanted pregnancy even before this project began. Perhaps because emergency contraception was not included in the norms until 1997, there are no available data in Ecuador on the use of this method. In spite of legal and social barriers, and the high risk of morbidity and mortality associated with its use, unsafe abortion is a serious public health, economic and social problem. Many women facing an unwanted pregnancy continue to seek abortion despite these risks. It is therefore critical that the government, the health sector and the social sector join forces to ensure that reproductive health care, including emergency contraception as an alternative to prevent unwanted pregnancy, be made widely available.

Ecuadorian Legislation and Reproductive Health

In the area of health, Ecuadorian legislation makes vague references to various aspects of reproductive health, addressing it primarily in the context of maternal and child health. The Constitution of Ecuador guarantees the "right to a quality of life that assures health, food, clothing, housing, medical care and essential social services." Parents have the right to determine the number of children they would like to have and educate, which is interpreted as the right for parents to plan their families. However, the Constitution does not have a specific chapter addressing reproductive health. The State develops the National Health Policy and determines its application through both public and private services. The law establishes the mechanisms for control and surveillance of health services in the private sector. The National

Health System, with participation from both the public and private sectors, functions according to the principles of universality, equity, solidarity and efficiency and, promotes technological development in accordance with ethical standards.

The emergency contraception project was initiated within a political/judicial environment where women's health policies did not exist. In addition, current legislation in force addresses only some aspects of reproductive health, principally as they relate to maternal/child health, and punitively in the case of abortion. There is no legislation concerning the use of family planning methods, except with regard to permanent sterilization, which is addressed in the code of medical ethics.

In 1995, CEPAM conducted a study to gather opinions about emergency contraception within the health sector. The study indicated that women from different social sectors and service providers are interested in information about emergency contraception. In fact, women's grassroots groups, the clergy and health professionals responded with unanimous acceptance of the use of EC in cases of rape. On a smaller scale there was some concern that EC might be rejected by some sectors of the population, specifically the religious sector because of its belief that life begins at the moment of fertilization. Service providers mentioned the need for adequate legislation about EC in order to facilitate greater availability of the method on a broader scale.

Through implementation of the project intervention, it has been possible to influence some aspects of the legal environment, specifically in the legitimization of the use of EC as an alternative to which all women have to the right of access. As a final note, resulting from this project, EC has been fully integrated into the services offered by the four participating institutions and has also been included as an alternative for women in the Family Planning Chapter of the "Reproductive Health Norms" of the Ministry of Public Health.

Training

Objectives

The initial training of the INOPAL Emergency Contraception project, in Ecuador, occurred June 10 - 13, 1997 in Quito. The objectives of this training were to (1) educate service providers on gender sensitive EC service provision and (2) enable them to similarly educate their peers. To fulfill these objectives, the training encompassed information on research logistics of the EC project, gender awareness raising and technical medical information on EC.

Trainers

At the request of the Ecuadorian collaborating agencies, two well-known international trainers were invited to lead the medical and gender components of the training: Dr. Soledad Diaz of the Instituto Chileno de Medicina Reproductiva, Chile, conducted the medical training component, while Dr. Elza Guevara Ruisenor, a psychology professor at the University of Mexico, developed and led the gender component. Additional sessions of the training were developed and led by the collaborating agencies.

Participants

The initial training targeted doctors and nurses who would be directly administering EC. Due to the medical personnel's time constraints, the workshop was limited to one day and in order to accommodate the 100+ participants, the same training material was presented on four consecutive days. (Please refer to Tables 1 and 2 for additional information on the participants).

Content

The training agenda consisted of an introductory section including opening remarks, a pre-test and background on the EC project. This was followed by a session on gender and two sessions on the technical medical aspects of EC provision. The training concluded with a review of the project survey instrument, a post test, an evaluation of the training, concluding remarks and distribution of diplomas.

The introductory session began with opening remarks, which were given by ICRW and one of the collaborating agencies on a rotating basis. This was followed by a pre-test, administered by ICRW and CEMOPLAF, which included two sections: (1) paired comparisons and (2) value assignments (please refer to the research section of this report for details). The Municipio of Quito then provided a historical background on the project, its aims, process and expected outcomes. CEPAM concluded this session by presenting findings from their research on the laws regulating family planning and contraceptive use in Ecuador and a survey of public opinion on EC.

Gender Component

The gender component of the training focused on defining gender and its importance both within the field of reproductive health service provision and more specifically within the emergency contraception project. It began with a brainstorm on characteristics usually associated with being a man or a woman and a discussion on how these characteristics can be present in either sex, the exception being that only women can bear children. This was followed by another discussion on how gender influences reproduction, sexuality and the sexual division of labor. This segment included a short video portraying a family going about its typical day, with very traditional role-playing by the mother and the father. Before the video was presented, participants were asked to consider whether or not such traditional role-playing still existed, particularly among certain segments of the Ecuadorian population. Following the video,

participants were asked how gender relations rated on a scale from one to ten in both the participants' personal lives as well as in the lives of potential EC users.

Another discussion centered on general gender assumptions and myths. This also encompassed the influence of gender on health services, particularly issues affecting emergency contraception use and service provision, such as: sexual relations, contraceptive choice, decision-making regarding family size, access to services and quality of care.

Emergency Contraception Component

The medical section of the training began with a participatory activity to link the gender and medical components of the training. Participants were divided into groups which explored issues relating to the use of emergency contraception among four target populations:

(1) Adolescents -- their sexual behavior, access to contraception information and methods, reaction to EC and special EC counseling needs.
(2) Adult women experiencing unwanted pregnancies -- their options for dealing with it, maternal mortality associated with abortion, their reaction to EC and special EC counseling needs.
(3) Adult women with risky sexual behavior -- what puts them at risk, what information they need for recognizing they are at risk, the decision-making process following a risky sexual relation and their special counseling needs.
(4) Victims of violence -- the various forms of violence and their consequences, information needed by victims of sexual violence, their decision-making process and special counseling needs.

Following this introductory activity, there were two technical sessions on the administration of emergency contraception. The first session included: a definition of terms, method options, reasons for use, and the application of combined and progestin-only pills. The

second session revolved around information for and evaluation of the user, patient counseling, side effects, followup and post EC family planning.

The emergency contraception session concluded with role-plays of various EC scenarios. After participants dramatized their particular situation, participants critiqued the EC information and counseling provided. The scenarios included:

(1) Two adolescents debating their options after unprotected sexual intercourse.
(2) A debate between a doctor advocating the pros of EC and a political figure arguing the cons of EC.
(3) A couple planning to have sexual intercourse and the woman advocating condom use while the man advocates EC use.
(4) A couple experiencing contraceptive method failure and going to a clinic to obtain EC.
(5) A young woman who had unprotected sexual intercourse and does not wish to be pregnant but her partner argues that he will marry her and wishes her to carry the pregnancy to term. The woman is seeking counseling.

At the conclusion of the training, a COF staffer reviewed the survey instrument to be used in the clinics by the medical personnel. Participants were then administered a post test and a training evaluation survey, both applied by CEMOPLAF. Various representatives of the collaborating agencies gave closing remarks and handed out diplomas.

Adjustments

As the training progressed, some adjustments enabled the workshop to become more effective. For example, on the first day, facilitators noted that the number of participants was higher than originally planned. This resulted in longer discussions during each session, making the day feel rushed. At the end of the first day, the project coordinators and ICRW staff met to review participant evaluations, discuss impressions and adjust the agenda's timing and content.

As a result, all sessions were shortened, except for the medical session. The timing of the following days improved significantly with these adjustments.

The gender presentation changed over the course of the four days, becoming more participatory and specific to the gender relations situation in Ecuador. At first, the gender video was not well received, particularly by the male participants who viewed it as too stereotypical. An introduction and debriefing to the video enabled participants to view it more objectively and agree that such relations still existed to a varying extent among different socio-economic groups.

Evaluation by Trainers and Participants

Overall the training was very well received. Trainees were motivated and eager participants in all the sessions. In some instances, they voiced their interest in additional time to deepen a few issue areas, particularly the medical and gender components. Some insisted on a lengthier debate regarding certain medical issues such as a women's menstrual cycle vis a vis the opportune moment of administering the EC regimen. There were, however, no significant disagreements, particularly regarding whether the method was considered an abortifacient.

Dr. Guevara commented that the gender component of the training enabled participants to gain a holistic vision of EC service provision beyond just the technical aspects. All participants had little gender training background, however, they seemed very interested in the theme, participated actively and learned the basic elements rather readily. Although she sensed that some participants were more resistant to the gender discussion than others, she believes all participants "moved forward" from their original view points. She recommended that the project develop a bibliography on gender issues in reproductive health which would enable participants to further educate themselves.

In Dr. Diaz's opinion, the training was well organized and coordinated and she was impressed by the quantity and quality of materials prepared ahead of time. She sensed from group discussions that while some participants readily agreed with the information presented on

the gender and emergency contraception issues, others were skeptical. She gathered that participants were not very informed about the reproductive health situation of the target population they serve, particularly on issues such as: maternal mortality, frequency of abortion and its consequences for the health and lives of women, adolescent sexual behavior and adolescent knowledge and use of contraception. During the role-plays, she noted, some participants omitted or incorrectly conveyed counseling information. "EC seems to be a conflictive theme for many of the participants who were considerably worried about the method in which EC operates," remarked Dr. Diaz. "This seems to be related to ethical/religious aspects surrounding EC and also to legal considerations since abortion is illegal in Ecuador. Some participants expressed their doubts and fears while others showed a resisting attitude." Dr. Diaz sensed that when it came to counseling, participants focused more on the technical aspects of EC administration rather than on gender aspects, such as, for example, the life situation of the user. She urged project coordinators to help participating organizations in focusing on the quality of care issues, including user needs and personal viewpoints. In her opinion, although each organization has social workers and counselors, it is especially important to encourage medical personnel to also be sensitive regarding quality of care issues. Overall, Dr. Diaz believes the training and research project is an excellent one and should it prove successful, be replicated elsewhere.

Research

The primary goal of the research component was to test the effectiveness of a gender and emergency contraception training intervention on providers' perceptions, knowledge and attitudes of emergency contraception. The primary policy and program question was what type and degree of change in knowledge and attitudes of EC could be expected from a one-day training intervention. A one day training format was selected to accommodate the busy schedule and time demands of the service providers. It was felt that such a workshop could be successfully replicated elsewhere in Ecuador. The research challenge became to assess whether the information communicated in such a short period resulted in significant changes in providers' understanding and perceptions of EC.

The project's principal intervention was a one-day training workshop. However, for practical and ethical reasons, it was felt that the one-day training should be followed with technical assistance. Provided by the project coordinators, this technical assistance consisted of site visits to the participating clinics. Coordinators also monitored and evaluated providers' knowledge of EC during the three month period after the training workshop, corrected any misconceptions or misunderstandings on how to administer EC, and provided an abbreviated training to clinic support staff. It is important to note that this technical assistance happened during the time period when providers were beginning to put into practice what they had learned from the training. It should be noted that the decision to include a technical assistance component reflects both practical needs and ethical considerations of the service organizations. The participating organizations began to provide EC immediately after service providers received training. To ensure that the providers were adequately prepared to administer EC in a conscientious and medically correct manner, it was felt that additional follow on assistance should be available, to ensure that women were receiving EC in a medically correct manner. This follow-on technical assistance reinforced the effects of training, and provided important insights on perceptions and practices of service providers.

As described below, both the training workshop and the actual implementation of EC, supported by on-going technical assistance, resulted in important changes in providers' understanding and perceptions of EC. Overall, providers' felt that they had acquired sufficient knowledge of the medical and gender dimensions in order to provide EC services. In terms of perceptions and attitudes, there was an increase in concern for the primary or underlying reasons and situations that resulted in women seeking EC services and stronger agreement that women should have the services. These changes in perceptions provide an opportunity to strengthen gender awareness among providers.

The main questions posed by the research were the following:

- What was the understanding of emergency contraception and gender prior to training?
- Did training create greater shared knowledge about emergency contraception and a greater appreciation of gender factors?
- What is the additional effect on knowledge, perceptions and attitudes from implementing EC, with technical assistance provided by coordinators?
- How did training, participating, practice and changes in perceptions, knowledge and attitudes vary by collaborating organization, profession and gender of the provider?
- What are the characteristics and experiences of the women seeking EC services, and what does this mean for service providers?

Study Population

The project's study population consisted of providers working in the clinics of the four participating organizations, and the women who sought EC services during the three month period immediately after the training workshop. A total of 109 service providers attended the training workshops. However, due to changes in staffing at the clinics and the busy schedules of the providers, only 86 providers completed the post-workshop evaluation questionnaires. In order to have comparable data across the three periods of evaluation (pre-test, posttest, and post-workshop), the following analyses are based on a total of 86 providers. Table 1 presents a disaggregation of providers by profession and organization.

As revealed in Table 1, the number providers varied among the organizations. The pattern that emerges is consistent with the size of the organizations, and the number of clinics from each organization participating in the project. As show in the data, CEMOPLAF had the greatest representation of providers, with about 41%, followed by COF (24%), CEPAM(19%) and the Municipality of Quito(16%). Overall, the differences in number of participants per organization are not so great to raise significant concerns about under-representation of any of the organization in the training.

A second pattern that emerges from the data in Table 1 is preponderance of physicians as participants, followed by obstetricians. Physicians accounted for 57% of the participants, and obstetricians represented another 37%, for a total of 97%. This is not surprising, since the training targeted the clinic staff who would be directly administering EC. In terms of the distribution of these professionals across the organizations, it is interesting to note the low representation of physicians from COF (only 4% of the physicians participating). COF does have a relatively high representation of obstetricians. The relatively low participation of physicians from COF in the training results from this organization's emphasis on adolescents. Finally, most of the remaining obstetricians work in CEMOPLAF clinics; both the Municipality of Quito and CEPAM do not use significant numbers of obstetricians in their clinics.

In addition to the profession of the providers, it is important to provide background information on the sex of the providers. As shown in Table 2, the majority of the providers participating in the training were women. Sixty-six (77%) of the 86 participants were women, and 23% were men. The greater participation of women is not surprising, given that overall more women than men work in the clinics of these organizations.

The second target group of the project was the women who, after the providers had received training, received EC services. As shown in Table 3, a total of 166 women visited the clinics of the participating organizations during the evaluation period after the workshop. For the most part, these women were equally divided among CEMOPLAF, COF and CEPAM; the Municipality of Quito attended to only 7 women during the study period.

Additional family planning, demographic, and socio-economic information on the women users is presented below.

Table 1 Profession of Provider by Organization

			Organization				
			CEMOPLAF	COF	M.Q	CEPAM	Total
Profession	Physician	Count	19	3	14	13	49
		% of Total	22.1%	3.5%	16.3%	15.1%	57.0%
	Obstetrician	Count	16	14		2	32
		% of Total	18.6%	16.3%		2.3%	37.2%
	Nurse	Count		2			2
		% of Total		2.3%			2.3%
	Educator	Count		1			1
		% of Total		1.2%			1.2%
	Other	Count		1		1	2
		% of Total		1.2%		1.2%	2.3%
Total		Count	35	21	14	16	86
		% of Total	40.7%	24.4%	16.3%	18.6%	100.0%

Table 2 Sex of Provider by Organization

			Organization				
			CEMOPLAF	COF	M.Q	CEPAM	Total
Sex	Male	Count	4	3	9	4	20
		% of Total	4.7%	3.5%	10.5%	4.7%	23.3%
	Female	Count	31	18	5	12	66
		% of Total	36.0%	20.9%	5.8%	14.0%	76.7%
Total		Count	35	21	14	16	86
		% of Total	40.7%	24.4%	16.3%	18.6%	100.0%

Operations Research Design and Methods

The operations research design used in this project was a single group pre- and posttest design (Fisher et al. 1991). A pretest of the perceptions, knowledge and attitudes on gender and emergency contraception of providers from clinics of each of the collaborating organizations was completed, followed by a posttest of the same providers immediately upon completing the one day training course. As mentioned above, the project completed a second posttest three months after the training. The results from this second test provide insights on whether additional training is necessary or whether program support in the form of technical assistance is sufficient to maintain acquired knowledge.

The operations research approach used in this study combines a number of systematic interviewing techniques to collect qualitative and quantitative data on the perceptions and knowledge of emergency contraception and the role of gender. More specifically, free lists, pile sorts and paired comparisons of key terms were used to identify the cultural domain of emergency contraception, including ideas about how gender is integrated. The information collected was analyzed through rank order and consensus analysis to reveal the priority themes/topics providers would emphasize during consultation before and after training, and the degree of consensus existing among providers on these priorities.

The project's approach to collecting and interpreting the data to answer the research questions posed above is presented below. The information is presented on the identification of key concepts and terms, the development of ranking and user questionnaires, and the use of focus groups.

Identification of Key Concepts and Terms

Prior to the research, little was known of the existing perceptions, knowledge and attitudes on emergency contraception and gender among service providers in Ecuador. Given the absence of any baseline information to guide the development of instruments to measure the effects of the gender and emergency contraception training, a first research priority was to identify the key concepts and terms that constitute the cultural domain of emergency contraception. In developing the project's data collection instruments, the following definition of cultural domains was used:

> "an organized set of words, concepts, or sentences, all on the same level of contrast, that jointly refer to a single conceptual sphere. The items in a domain derive their meanings, in part, from their position in a mutually interdependent system reflecting the way in which a given language or culture classifies the relevant conceptual sphere" (Weller and Romney 1988: 9).

It was important to the research that providers were allowed to use their own terms for describing any cultural domain of emergency contraception. Therefore, a first step in defining a cultural domain of emergency contraception was to elicit key terms or concepts individuals use to describe and understand what EC is and is not. The data collection technique of free listing was used (Weller and Romney 1988).

Prior to the training workshop, free lists were collected from 59 service providers (physicians, obstetricians, and nurses) from the collaborating organizations. Providers were asked to list all the words that they think of when they hear or think about "emergency contraception." The breakdown of these providers by organizations was: 25 (CEMOPLAF), 13 (COF), 15 (Municipio de Quito) and 6 (CEPAM). All combined, a total of 167 terms were elicited. It is important to clarify here that providers were not requested to free list separately on the cultural domain of gender. Rather, the approach of the project was to conceptually view gender with the domain of emergency contraception. Thus, it was hoped that a number of the

key terms and underlying dimensions of the cultural domain of emergency contraception would represent a sub-domain of gender.

The providers' lists of key terms were analyzed using the computer program ANTHROPAC to produce a frequency list, a respondent by term matrix, and a correlation of each provider's list with the all the terms mentioned (Borgatti 1992). Using the information produced by ANTHROPAC in follow up interviews with providers, we were able to identify those terms that were synonyms, cognates or used by only one person. As a result, we were able to reduce the number of key terms to 40. To further test for semantic redundancy in the 40 terms, two additional analyses were undertaken. First, the sorting of the free listed terms in piles was used to identify if some of the remaining terms represented clusters or subgroups of other terms. For example, the term religion might be an adequate cover term for a number of more specific terms, such as Catholic, church, Pope, God, etc. In the pile sort task, 13 providers were asked to sort cards, each containing one word from the list of 40 terms, into piles so that items in a pile are more similar to each other than they are to items in separate piles (Weller and Romney 1988: 20). As a result, a reduced list of key terms numbering 14 was identified (Table 4). As described below, these 14 terms were used to create a paired comparison questionnaire (Wellor and Romney 1988). This questionnaire was used to assess changes in providers' knowledge and attitudes on EC as a result of the training and provisioning of EC.

The lists of 40 and 14 terms were also reviewed extensively by the project's coordinators and the workshop trainers. Drawing from the list of 40 terms and the coordinators' and trainers' own knowledge of EC and the goals of the project, a number of additional terms that were not included in the list of 14 terms were identified. Although we were confident that the 14 remaining terms were representative of the provider's cultural domain, there were a number of concepts or beliefs that were important to researchers and trainers that were not mentioned by the providers. In part this is due to the fact that the free list and pile sort tasks were completed prior to the providers receiving training on EC and the related gender issues. The researchers and trainers had their own cultural domain of EC and gender issues, which included some terms or words not mentioned by the providers. These terms and concepts would be included in the

training materials. Thus, it was important to include in the final list of terms for EC and gender, key concepts or issues deemed relevant from the research, programmatic and policy side. As a result, a second list of 24 key terms was created, which included the 14 key terms plus a few terms added by the providers and a few terms resurrected from the list of 40 terms (Table 4). This list of 24 terms was used to create a rating questionnaire, which was used to evaluate changes in providers' overall knowledge and attitudes on EC as a result of training and practice.

Table 4: Key Terms for Describing the Cultural Domain of Emergency Contraception

List of 24 Terms for Rating Questionnaire	List of 14 Terms for Paired Comparison Questionnaire
1. Unwanted pregnancy	1. Unwanted pregnancy
2. Communication with partner	2. Communication with partner
3. Unprotected intercourse	3. Unprotected intercourse
4. Reproductive rights	4. Reproductive rights
5. Casual sexual relations	5. Casual sexual relations
6. Rape	6. Rape
7. Prevent abortion	7. Prevent abortion
8. Highly effective	8. Highly effective
9. Sexual rights	9. Sexual rights
10. Dosage	10. Dosage
11. Medical side effects	11. Medical side effects
12. Promiscuity	12. Promiscuity
13. Frequent usage	13. Frequent usage
14. Induces abortion	14. Induces abortion
15. Adolescents	
16. Illegal	
17. Immoral	
18. Sex workers	
19. Sexual values	
20. Free and informed decisions	
21. Sexual coercion	
22. Method Failure	
23. Stable partnership	
24. Alcoholism	

Workshop and Post-Workshop Evaluation Questionnaires

The lists of 24 and 14 terms were used to create separate questionnaires to assess the perceptions, knowledge and attitudes of providers before and after having completed the training workshop. The list of 24 words was used to create a rating questionnaire. Respondents were asked to rate the strength of the association between each word and emergency contraception. The strength of the association was measured on a scale of 1 to 10, with 1 representing little or weak association, and 10 representing strong or maximum association. The principal purpose of the rating questionnaire was to assess providers' general level perceptions and understanding of emergency contraception.

The list of 14 terms was used to create a paired comparison questionnaire. The purpose of the paired comparison questionnaire was to determine providers' ranking of topics or issues to be discussed during their consultation with women seeking EC. For each pairing of terms, providers were asked to select the term that they would give more emphasis to during the consultation. ANTHROPAC was used to generate all possible pairs of the 14 words. A total of 91 pairs of words were generated (n(n-1)/2).

As described in the above, providers participating in the training workshop completed both the rating and paired comparison questionnaires at the beginning of the workshop, prior to receiving any workshop materials or information, and again at the end of the workshop, after all training activities had been completed. Comparison of the change in responses to the rating and paired comparison questions provides insights on how perceptions, knowledge and attitudes changed as a result of the training intervention.

In addition to the rating and paired comparison questionnaires, a short evaluation form was also administered at the end of the workshop. This questionnaire sought information on how well the workshop was organized and implemented, whether the objectives were clear, the location and materials adequate, etc. The questionnaire also collected content information, including whether information was clear, accurate, useful and whether discussion groups

facilitated comprehension and dialogue. A third and important area of questions on the evaluation asked for the degree of acceptance of EC and gender, and the level of importance of considering gender issues when providing EC. Both these questions were asked for the periods before and after training.

Questionnaire for Users of EC

An important post-workshop activity was the planned provisioning of EC. Prior to the workshop, the collaborating Ecuadorian organizations had not been providing EC, except for CEPAM. Prior to the training workshop, the collaborating organizations had prepared promotional materials and EC packets. These materials and instructions for their use were provided to workshop participants, for their clinics.

To monitor the administration of EC, and to collect important background information on women users, a short questionnaire was developed. The questionnaire collected important obstetric, gynecological, family planning and background socio-economic information. In addition, questions were asked about the topics or themes that were discussed during the consultation with the provider. The possible themes or topics were identical to the14 terms in the paired comparison questionnaire completed by the provider in response to the question of topic they would emphasize in their discussions with women seeking EC. Finally, the questionnaire contained a series of follow up questions, to be asked after the woman had completed the prescribed EC regimen.

Focus Groups

A final methodological undertaking of the project was to organize focus groups to discuss the results of the paired comparison questionnaires and the experiences of providers in administering EC. COF, CEPAM and the Municipality of Quito each organized two focus groups of, on average, five providers who had attended the workshop and had administered EC. CEMOPLAF organized three groups. The groups represented the range of providers for each

organization. For example, CEPAM included providers from the Servicios Medicos Legales de la Policia, the Comisaria de la Mujer y la Familia and the servicios de atencion primaria del Ministerio de Salud Publica. The focus group information was used extensively to interpret changes in the ranking of key terms after training and again after practice.

The Impact of Training

Information from workshop evaluation and paired comparison questionnaires were used to assess how providers' perceptions, knowledge and attitudes of emergency contraception changed after receiving training. Presentation of the effects of training begins with a discussion of the increased acceptance of EC and the importance of including gender, followed by more specific results of changes in topics providers would emphasize during consultation. Because of the collaborating organizations' principal concern with providing training that would be useful at the clinic level, during the actual consultation prior to administering EC, the following analysis draws on the paired comparison information. It should be mentioned here that the information from the paired comparison and the rating questionnaire were very similar. As mentioned earlier, the rating questionnaire seeks knowledge, attitudes and perspectives without reference to any specific context, such as during the consultation.

Increased Acceptance of EC and Gender

Among the providers who participated in the training workshop, there was a substantial improvement in their level of acceptance of EC after receiving training. Figures 1 and 2 provide providers' responses to the question "what was your level of acceptance of EC," pre- and post-training, respectively. As shown in the figures, there was a substantial increase in providers' acceptance of EC after training.

There was also a substantial increase in providers' belief in the importance of gender to the provisioning of EC. Figures 3 and 4 present providers' responses to the question of "how important is it to include a gender perspective in the provisioning of EC, pre- and post-training

respectively. As shown in the figures, there was a substantial increase in providers' belief that it was important to include a gender perspective.

Figure 1. Acceptance of EC prior to Training

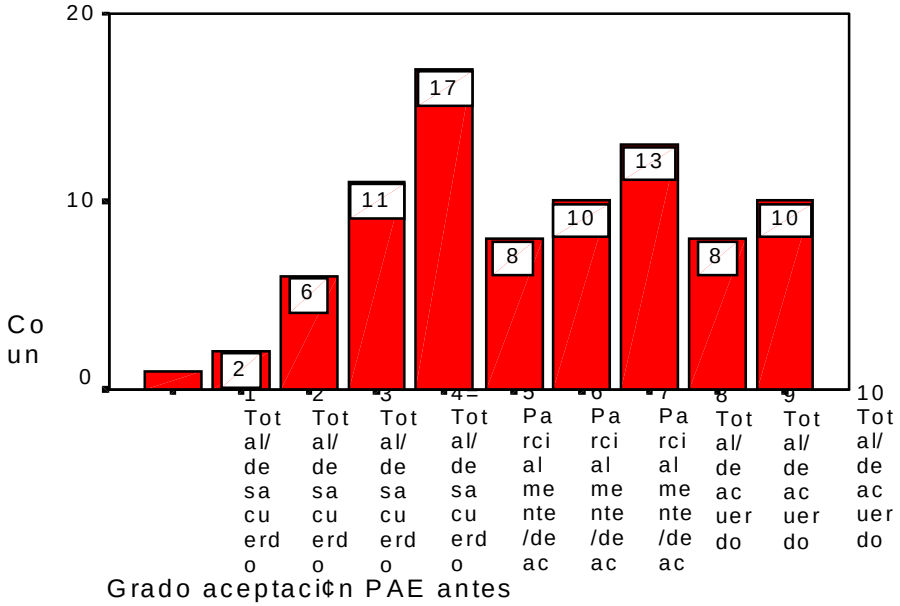


Figure 2. Acceptance of EC after Training

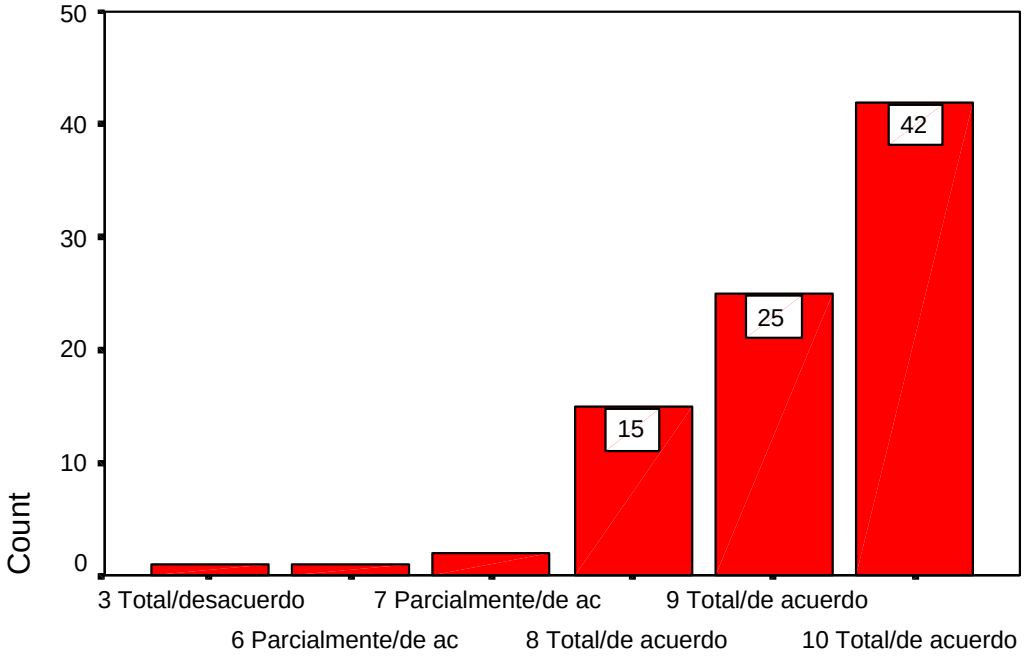
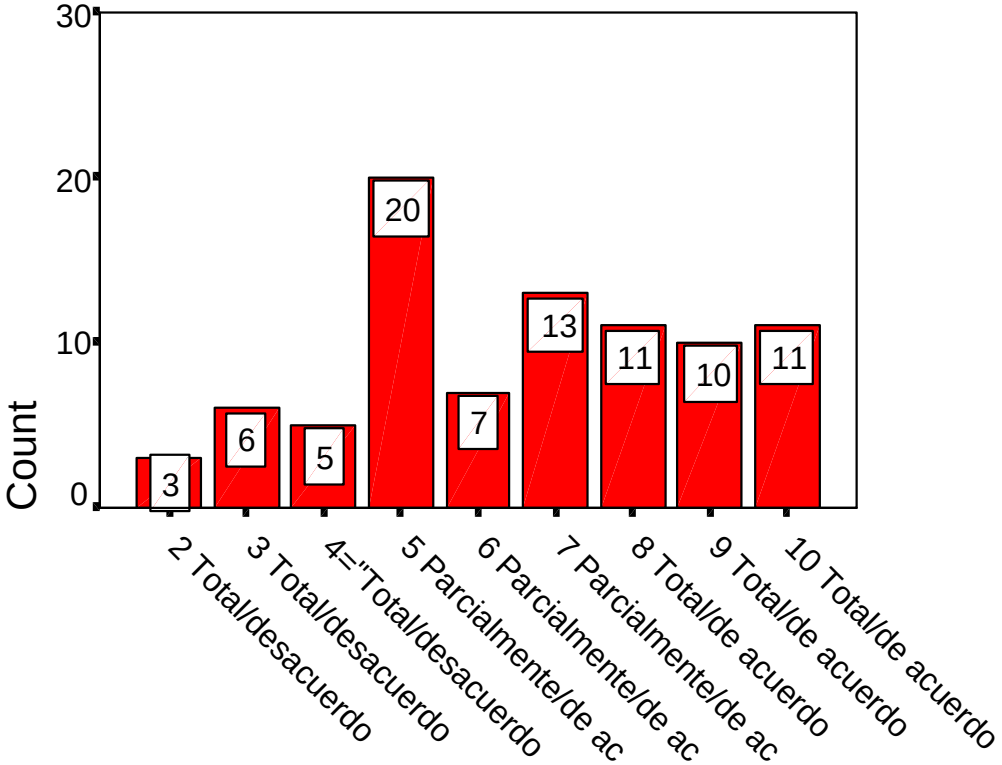


Figure 3. Importance of Including Ge Prior to Training



Prespectiva G,nero en PAE antes

Ranking of Key Topics and Themes: Paired Comparisons

The objective of the paired comparison exercise was to identify which topics or concepts providers felt should be emphasized during their consultation with women seeking EC. The results of the pretest and posttest paired comparison evaluation are presented in Table 5.

Table 5: Paired Comparison of 14 Key Terms

Key Term	Pretest Rank	Posttest Rank	Change in Rank Order
Unwanted Pregnancy	1	1	0
Communication with Partner	2	9	-7
Unprotected Intercourse	3	2	+1
Reproductive Rights	4	8	-4
Casual Sexual Relations	5	4	+1
Rape	6	3	+3
Prevent Abortion	7	7	0
High Effectiveness	8	6	+2
Sexual Rights	9	10	-1
Dosage	10	5	+5
Medical Side Effects	11	11	0
Promiscuity	12	12	0
Frequent Usage	13	13	0
Induces Abortion	14	14	0

Information from providers who participated in the focus group provide insights on the rationale of providers for their ranking of topics, and why that ranking did or did not change after receiving the gender and EC training. Key findings from Table 5 include:

Both before and after training, providers ranked **unwanted pregnancy** as the most important topic to discuss with women. Pre-training, because of a general absence of understanding of EC, providers could only relate EC to unwanted pregnancy, and not to either the situation that resulted in a women needing EC or to the procedures for administering EC. First and foremost providers wanted to confirm the fact that should the woman become pregnant, that it would be unwanted. The high ranking of unwanted pregnancy reflects a problem-solving approach of the providers: how to avoid an unwanted pregnancy. Underlying this problem-solving orientation is the knowledge that unwanted pregnancies are more likely to lead to abortions, which in turn result in increased maternal mortality.

Providers' high ranking of **unwanted pregnancy** continued in the posttest. This is because the training reinforced providers' concerns about unwanted pregnancies. Information presented in the workshop emphasized that one of the benefits of EC was the avoidance of unwanted pregnancies and it also reduced the need for abortions.

A second important finding from the paired comparison test was that in the pretest providers ranked **communication with partner** as their second priority topic for discussion during consultation. To a significant degree, this reflects what providers reported as a "machista" viewpoint which holds that any decision by a woman related to the number of children she would like, her use of birth control methods, and her pregnancy, real or possible, should be discussed with her partner, regardless of the stability of the relationship. A strong feeling among some providers was that communication among partners is essential when making decisions of this nature. For couples (parejas) it was felt that one person should and could not take responsibility alone for such a decision. Pretest, providers who envisioned attending to a woman involved in a long-standing relationship reported feeling that such communication was essential. Any decision to use EC to help avoid pregnancy should be discussed, and that both

parties should be encouraged to communicate their perspective. Communication is important in order to avoid a "compromised relationship" that does not respect the rights of women or man. As one provider referring to the situation before training put it:

> "Por el desconocimiento del mismo metodo PAE, asumimos que la poca comunicación en pareja era un factor importante para que se produzcan embarazos no deseados, pero que en su resolucion debian participar los dos"

This viewpoint on the need for communication among couples was contrasted with the lack or absence of communication in what providers perceived as casual sexual relations. As reported in one focus group, by definition there is no communication in casual sexual relations, except to request EC should the need arise.

The most dramatic change in the ranking of terms/concepts between pre- and posttest was the decline in priority assigned to communication with partner. After receiving training, providers ranked communication with partner in 9th place. A number of reasons for this decline in emphasis were reported. First, as noted in one focus group, communication with partner was still seen as important in the cases where the relationship permits such discussion, but in absence of this, the woman should be the one who decides:

> "Creemos que en los casos en los que se puede discutir estos temas en pareja, se lo debe hacer, pero si no, la mujer debe decidir lo que debe hacer"

However, a stronger position that emerged after training, and post practice, was that a woman should be able to decide for herself whether she wants to use EC to avoid a possible unwanted pregnancy. That she is the only one who should make decisions about her body, life and fertility. As one provider commented:

> "En los post test las comunicación en pareja baja notablemente porque luego de la capacitacion y de la practica nos dimos cuenta que cuando se trata de decidir tener o no un hijo, la que tiene la ultima palabra es la mujer"

Second, much of the training emphasized situations where women would seek EC because of method failure or unprotected intercourse in casual relationships, among adolescents,

or due to rape. In these types of sexual relations, there is no long-standing partner with whom to communicate, and a number of providers commented on how this reality changes the need for a woman to communicate her decisions:

> "En una relacion sexual casual, o sin proteccion la mujer asume mayores responsabilidades, por lo tanto el decidir sobre un embarazo deseado o no es absolutamente su decision." Or,

> "Muchas veces no va haber la posibilidad de decidir en pareja, mucho peor en los casos de violacion"

Providers also reported in the focus group discussions that in these types of sexual relations, there is no communication, which is one reason why you need EC.

The gender and EC training increased awareness among providers of the need to better understand and take into consideration the sexual realities of women that result in the need for EC. These realities include having **unprotected intercourse and casual sexual relations, and the reality of rape and violence against women.** While the topics of unprotected sex, casual sexual relations, and rape were all ranked relatively high by providers prior to training, all three terms or topics were given greater priority by providers following training. This is particularly the case with rape, which was ranked 3rd after training. Providers reported that they feel it is important to discuss with women the risks of **unprotected sex and casual sexual relations**, and the family planning and reproductive health options available to women to protect themselves from unwanted pregnancies, STDs and HIV/AIDS.

.

The felt need to discuss **reproductive rights** declined after training. In discussions with providers, two explanations for this decline emerged. First, providers felt it was more relevant and important to discuss other topics, such as unprotected sex, and dosage. Second, although the gender training component of the workshop included discussion of reproductive and sexual rights, providers felt that the concept of reproductive rights is unclear. As one provider commented:

> Derechos reproductivos bajó porque nunca se conceptualizó el término "Derechos Reproductivos", por eso fue un concepto que no quedó claro entre los proveedores.

Also, providers questioned whether it was feasible to discuss reproductive rights, when most people don't know their rights in general:

> "Pensamos que la gente en general no conoce sus derechos, mucho menos los derechos reproductivos".

A final reason for a de-emphasis on reproductive rights because it might create an akward situation between the provider and patient, and thus possibly reduce communication. This reduced comfort level could have negative consequences in terms of successfully providing EC to women.

The gender training raised the issue of reproductive and sexual rights, but it is clear that the time available for such discussion was insufficient. After training, providers reported that they did have a better idea of what reproductive rights consisted of, but that they were not in agreement or clear on how it should be incorporated into their provision of EC. Rather, providers reported that post-training they felt that they should focus more on the immediate causes of why women need EC in the first place: unprotected sex, casual sexual relations, rape and method failure (see above). Although supportive of women's reproductive rights, providers had difficulty in conceptually integrating reproductive rights into their daily practice

After training, providers were in agreement that more emphasis should be given to explaining the correct **dosage** for EC. Prior to training, providers did not feel that extra attention needed to be focused on explaining the dosage. Rather, dosage of birth control pills was seen as something rather straightforward and uncomplicated. However, during training, discussion focused on the confusion women may have about dosage due to the side effects of EC such as vomiting, and that there could also be confusion about the timing of when to take additional pills. Training also emphasized many women taking additional birth control bills as part of the EC regime are doing so while under great stress and anxiety, without full understanding of how the pills work to prevent pregnancy. Providers left the workshop with a greater appreciation of the need to better explain how and when to take the pills and how the medication works to prevent pregnancy.

A surprising finding was that both before and after training, providers did not seem particularly concerned about the need to discuss the medical side effects of EC, such as headaches, nausea and vomiting. A strong assumption of the project staff prior to the project, in part based on experiences with EC in other countries, was that these uncomfortable side effects could make many women discontinue the regime before completing the second dosage, and lead to situations of confusion about whether to take additional pills in the case of vomiting (see above). However, both pre- and post-training providers did not express particular concern about these side effects. Although seen as being uncomfortable to be sure, the general perception was that they are relatively minor compared to more complex and long-term health consequences of other medication. As expressed in focus groups, providers felt that these "costs" of taking EC were relatively insignificant given the important benefits of taking the pills: avoidance of an unwanted pregnancy. Although training emphasized that women, particularly women who are poor and have little education, might be less inclined to use EC and/or use it correctly due to its possible side effects of vomiting and nausea, providers continued in their perspective that the side effects of EC are comparatively minor

Finally, the key terms of **promiscuity, frequent use and promotes abortion** were included in the paired comparison evaluation in order to investigate what is often reported to be some negative consequences of promoting EC: that it will be used frequently as a regular birth control method, that its ease of access and use will lead to greater promiscuity, particularly among adolescents, and that it actually is or promotes abortion. These terms were ranked the lowest in both pretest and posttest, and post-practice as shown below. Although there were exceptions, the vast majority of providers were in strong agreement that these myths or negative consequences were not associated with EC, and therefore should not comprise a significant part of their counseling. Rather, as shown in the above discussion, counseling should begin with an assessment of the situation that created the need for EC, followed by medical matters of dose and side effects. It should be noted that a few providers, perhaps because of religious beliefs, continued to perceive EC as an abortifacient, and because of this would not prescribe it, except perhaps in the case of rape

Increased Consensus Among Providers on EC

An important indicator of the effect of training on providers' knowledge of EC and gender is the degree to which there was increased agreement or consensus among providers in terms of their rankings of topics to be discussed with women. To test whether training resulted in more agreement by providers, the ranking of the 14 keys terms were analyzed using consensus analysis in ANTHROPAC. Consensus analysis is both a theory and method. From a theoretical perspective, it specifies the conditions under which more agreement on the answers to a "test" (eg. Paired comparison) indicates more shared knowledge; as a method, it provides a way to uncover the culturally correct answers to a set of questions in a situation of intra-cultural variability (Borgatti 1992). Consensus models focus on a universe of respondents, rather than items, and seek to measure the competence of each respondent and to construct culturally-correct responses to a series of questions (Weller and Romney 1988). The culturally correct answer to a question is a function of the amount of agreement among respondents on the answer to that question. Two key assumptions of consensus theory are 1) that each informant (re: provider) has some knowledge of the subject matter under study (eg. Emergency contraception and gender), and 2) that correspondence between any two informants in their answers is a function of shared knowledge about the subject matter (Weller and Romney 1988).

Applied to the paired comparison data, consensus analysis allows us to ask the following questions: 1) to what extent do providers share knowledge about, or are in agreement about what topics they should discuss with women users of EC; 2) are there sub-domains in this knowledge which may indicate important subgroups among providers; and 3) what is the estimated knowledge level of each provider vis a vis the overall "culturally appropriate" as derived from the overall pattern of pattern of ranking by providers. It should be emphasized here that what is defined as culturally appropriate is a function of the providers' pattern of responses to the paired comparison questionnaire. It is derived from the data, and is useful in situations where no "gold standard" measure is available. This is most definitely the case in emergency contraception: there are no a priori right or wrong rank orders of terms; the "right" order is that on which there is sufficient consensus among providers.

The results of the consensus analysis for the pre- and posttest information are presented in Tables 6 and 7. What concerns us here is whether there was significant agreement among providers on the rank order of the 14 terms. The results are presented as eigenvalues loading on three factors. The consensus model can be said to fit if the ratio of the first eigenvalue is three times the ratio of the second eigenvalue. As can be seen in Table 6, the ratio between the first and second factor is 1.845. The model does not fit, suggesting that prior to training, providers did not share one cultural model on EC and gender, measured in terms of their responses to the paired comparison of the 14 key terms. There was not widespread consensus on the ranking of terms.

Table 6. Consensus Analysis Results: Pre-Test

EIGENVALUES

FACTOR	VALUE	PERCENT	CUM %	RATIO
1:	24.035	51.0	51.0	1.845
2:	13.027	27.6	78.6	1.289
3:	10.104	21.4	100.0	
	47.166	100.0		

Respondent Reliability = 0.961
Average: 0.470
Std. Dev.: 0.242

The results of the consensus analysis post-training are presented in Table 7. The most significant difference between Table 6 and 7 is the high ratio between the first two eigenvalues. Factor 1 is 5.408 times larger than factor 2, well above the 3.0 ratio cut off for consensus. The results suggest that after receiving the training, providers were in strong agreement on rank order of terms, and that the overall pattern of "right" answers can be used to construct the "culturally correct" pattern of responses. The EC and gender training was very successful in helping providers reach consensus on the topics that they felt were important to discuss with women seeking EC.

Table 7. Consensus Analysis Results: Posttest

EIGENVALUES

FACTOR	VALUE	PERCENT	CUM %	RATIO
1:	42.737	73.6	73.6	5.408
2:	7.903	13.6	87.2	1.067
3:	7.404	12.	100.0	
	58.044	100.0		

Respondent Reliability = 0.985
Average: 0.662
Std. Dev.: 0.242

The Impact of Practice: Postworkshop

Immediately after the providers had completed their training in EC and gender, the participating clinics began to offer EC services. The participating organizations had developed a packet of EC materials that included instructions to the providers and user, and a dosage of birth control pills. This section provides additional information on the women who sought EC services during the three month follow up period to the workshop, and provides the results of the final post-workshop paired comparison test. The objective of this test was to assess how practice had affected the rank order of key topics to discuss with women seeking EC.

Women Users of EC

As mentioned earlier, 166 women sought EC services at the clinics of the four participating organizations during the three month postworkshop period (Table 3). Descriptive information on age, education and occupation of the women who sought EC services are provided in Tables 8, 9, 10. The reasons for women seeking EC services are provided in Table 11. The most frequent reported reasons for seeking EC was because of unprotected sexual intercourse (67% or 109 cases), followed by rape (18% or 30 cases) and method failure (13% or

22 cases). Most of the women seeking EC because of unprotected sexual intercourse sought services at CEMOPLAF and COF. Not surprisingly, 77% of the women seeking EC because of rape attended CEPAM clinics.

Table 9. Education of Women Seeking EC by Organization

			Agencia:				
			CEMOPLAF	COF	M.Q	CEPAM	Total
Instrucción	Ninguna	Count	1			1	2
		% within Instrucción	50.0%			50.0%	100.0%
	Prima 1-3	Count	4	1		4	9
		% within Instrucción	44.4%	11.1%		44.4%	100.0%
	Prima 4-6	Count	4	2	2	5	13
		% within Instrucción	30.8%	15.4%	15.4%	38.5%	100.0%
	Secun 1-3	Count	8	8	2	4	22
		% within Instrucción	36.4%	36.4%	9.1%	18.2%	100.0%
	Secun 4-6	Count	13	35	3	26	77
		% within Instrucción	16.9%	45.5%	3.9%	33.8%	100.0%
	Especial	Count	9	5		8	22
		% within Instrucción	40.9%	22.7%		36.4%	100.0%
	Superior	Count	5	4		4	13
		% within Instrucción	38.5%	30.8%		30.8%	100.0%
Total		Count	44	55	7	52	158
		% within Instrucción	27.8%	34.8%	4.4%	32.9%	100.0%

Ranking of Key Topics and Themes: Paired Comparisons

The results in Table 12 compare the findings immediate post-training (same as right column in Table 5) with changes that were found after three months of implementing EC, as measured by the paired comparison test.

Table 12. Paired Comparison of 14 Key Terms (Posttest vs. Post-Practice)

Key Term	Posttest Rank	Post-Practice Rank	Change in Rank Order
Unwanted Pregnancy	1	4	-3
Unprotected Intercourse	2	1	+1
Rape	3	2	+1
Casual Sexual Relations	4	3	+1
Dosage	5	5	0
High Effectiveness	6	8	-2
Prevent Abortion	7	6	+1
Reproductive Rights	8	7	+1
Communication with Partner	9	9	0
Sexual Rights	10	10	0
Medical Side Effects	11	11	0
Promiscuity	12	12	0
Frequent Usage	13	13	0
Induces Abortion	14	14	0

One overall finding when comparing posttest with post-practice, is that there is in general less change in ranking of terms, compared with pre- vs. posttest.

In terms of specific changes in rank order, the most important is the decline in **unwanted pregnancy and the continued increase in focus on unprotected sexual intercourse, rape, and casual sexual relations.** A consistent finding from the focus group data from all four

participating organizations was that women are seeking EC primarily in response to either having unprotected sex, to being raped, or because of casual sexual relations (see also Table 11). Although women are concerned about unwanted pregnancy, they express their reason for seeking EC in terms of the causes that might lead to an unwanted pregnancy. Women are seeking EC for the underlying reasons behind an unwanted pregnancy.

Based on their experience in providing EC, providers now know that women coming in do not want to become pregnant, and therefore de-emphasize their concern for whether this is an unwanted pregnancy; they now assume it is an unwanted pregnancy. Therefore, women focus on causes that result in women needing EC, such as unprotected sexual intercourse, method failure, or rape. Often in the cases where a woman comes with reasons focused on an unwanted pregnancy, it is already too late (post 72 hrs.). Thus, women seeking EC are doing so because of having unprotected sex, due to method failure, or because of rape. They clearly want to avoid a pregnancy, but the reasons express for wanting EC has more to do with the sexual act that might result in a pregnancy.

For providers, the effect of learning through practice that women's reasons for seeking EC have more to do with the sexual acts that put them at risk of an unwanted pregnancy, rather than because of already being pregnant and not wanting to continue, functioned to move the discussion beyond a concern for whether any pregnancy was wanted or not, to a focus on behavioral and sociocultural dimensions for women. This shift in terms clearly reflects the motives and situation of the women users.

There were slight changes in ranking of **prevents abortion and efficiency.**

Other results of comparison of posttest with post-practice is that **communication with partner** remained a low priority, in large part reflecting the type of underlying causes and situations of the women who are seeking EC; they are not in stable, long-term relationships

Increased Agreement due to Practice

Consensus analysis was also run on the postworkshop paired comparison data. The results, presented in Table 13, mirror those found post-training. As was the case for the training, practice reinforced agreement among providers on the ranking of topics for discussion with women users of EC. The ratio of factor 1 to factor 2 increased, as compared to post-training. This ratio at 6.002 is well above the cut-off of 3.0.

Table 13. Consensus Analysis of Results: Post-Workshop

EIGENVALUES

FACTOR	VALUE	PERCENT	CUM %	RATIO
1:	45.533	77.5	77.5	6.002
2:	7.587	12.9	90.4	1.352
3:	5.612	9.6	100.0	
	58.732	100.0		

Respondent Reliability = 0.988
Average: 0.705
Std. Dev.: 0.180

Conclusions/Recommendations

1. There is a substantial interest in training on gender and emergency contraception in Ecuador. The providers who participated in the training obtained an understanding of EC that was adequate for them to begin to provide services. It should be reemphasized that the type of training provided was completed in one day, and thus did not represent a significant time investment on the behalf of busy professionals.

2. The project found substantial openness by providers to the concepts and methods of EC. Prior to the project, it was not known to what degree providers would be open to considering

gender issues and EC, or whether they would put into practice what they had learned. In the unfortunate cases of rape, there is unequivocal acceptance and support of the need to provide EC as part of family planning services.

3. The project found substantial interest in the user population; a good response without extensive promotion, suggesting a high demand.

4. The training and follow-on technical assistance provided by the project team was successful in helping to institutionalize EC services within the four participating organizations. They were not as successful at getting the Ministry of Public Health to incorporate EC.

5. The training produced important changes in the perception by providers of EC, which were reinforced during the post-training period of implementing EC. For the most part, providers are not biased against providing EC, once they have an understanding of it. In the case of rape, there is widespread consensus that EC should be available to women.

6. A main finding from implementation is that the vast majority of women seeking EC do not want to become pregnant, and therefore providers focused their counseling on the reasons or causes or consequences of unprotected sex, method failure, and rape. The effects of implementing EC suggest that counseling can move beyond a focus on whether this is an unwanted pregnancy, and instead focus on the behavioral and sociocultural dimensions of unprotected sex, rape, methods failure.

7. Reproductive rights and sexual rights are currently difficult and diffuse topics in the socio-cultural context of Ecuador (and many other countries), which is why they are not mentioned more in practice and are not seen as related or that relevant to EC. There is an absence of a culture of rights. Therefore, it was not conceptually possible to perceive EC as a woman's right to avoid an unwanted pregnancy; EC is only viewed as an option or alternative.

Recommendations

1. Promote training and dissemination of EC on a wider scale, targeting in particular the Ministry of Public Health.

2. Facilitate reflection over EC as a woman's right, in the context of women's reproductive health and rights.

3. Provide accurate and systematic information on EC to providers and women, to help overcome misinformation, fears and myths held by men and women.